

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	<p>This visit was for an annual recertification and state licensure survey. This visit included the investigation of complaint #IN00127087.</p> <p>Complaint #IN00127087 - Substantiated. Federal and State deficiencies related to the allegations are cited at W149, W154 and W407.</p> <p>Survey Dates: April 15, 16, 17, 22, 23, and 25, 2013</p> <p>Facility Number: 000939 Provider Number: 15G425 AIM Number: 100368660</p> <p>Surveyor: Jo Anna Scott, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/30/13 by Ruth Shackelford, Medical Surveyor III.</p>	W000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/25/2013	
NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 1 of 4 sampled clients (client A), the facility failed to implement policy and procedure in regard to the client's stealing and AWOL (Absent Without Leave) behaviors.</p> <p>Findings include:</p> <p>The facility's incident reports were reviewed on 4/15/13 at 1:05 PM. The reportable incident reports indicated the following:</p> <p>-4/5/13 "Day program staff were discussing with [client A] his recent behaviors and why he had eloped from the group home twice and had taken property from another client at day program. [Client A] told the day program staff that he eloped 'Because [home manager] cussed at me.'</p> <p>-4/4/13 "[Client A] ignored staff's prompts to join other clients in the game room for an activity choosing instead to dart out the backdoor and run down the street. Staff were able to keep visual contact at all times. Staff were able to convince him to return home after a few</p>	W000149	<p>Client A was admitted to the group home on 6/28/12. Behaviors were not fully disclosed by family members either in frequency, intensity or even target behaviors. Client A's behaviors, though problematic, were within normal limits until September of 2012. Many adaptations were made to client A's program, staffing, and physical environment in attempts to better serve the needs of client A. Adaptations and protective measures were instituted to protect other clients within the home as well.</p> <p>Support team members agreed that a more restrictive placement would better serve client A and the other clients in the home. Client A was referred for a more restrictive placement (ESN) the week of 9/24/12. In the more than seven months since this client was referred no placements options have been available for client A.</p> <p>Quality Community Services is terminating placement for client</p>	05/25/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/25/2013
NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>minutes."</p> <p>-4/3/13 "[Client A] was in the living room talking with the home manager about a cell phone that was in his possession that did not belong to him. He became angry and ran out the door of the home and darted down the street. AWOL procedures were implemented by staff and his BSP (Behavior Support Plan) was followed. The police were notified. Staff located [client A] a few blocks from the home in a game store. Staff were able to convince [client A] to willingly return home. [Client A] was AWOL for approximately 2 hours and 15 minutes."</p> <p>-3/30/13 "[Client A's] mother reported today (4/3/13 @ (at) 3 PM) that on Saturday (3/30/13) [client A] was in the yard with her husband. Her husband looked down at an item in the yard. When he glanced toward where [client A] was standing near him, [client A] was running away down the street. He ran to a neighbor's property in a rural area before [client A's] parents were able to catch up to him and convince him to come home."</p> <p>-12/2/12 "Upon returning to the group home from an outing to a [name of school/city] basketball game, [Client A] walked around the staff person who was attending to him. When the staff person</p>		<p>A. Until the time of discharge, Quality Community Services will continue the current program, staffing, and physical environmental supports for client A.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>turned to redirect him, he was out of sight and had darted away. The 2 staff people on duty initiated AWOL procedures/notifications searching the house immediately and calling the home manager. [Client A] was not in direct line of sight for approximately 5 minutes." Follow-up report dated 12/7/12 indicated the following: "[Client A] darted past the staff person that was zoning him at that time. The staff person tried to follow and maintain visual contact but was unable to match [client A's] speed. The group home is a very large older home with 2 stories and many rooms. This makes it difficult to determine if [client A] has eloped or just darting quickly away from staff and going to another area of the house. The staff followed procedures and searched the house first before beginning the exterior search and AWOL notification protocols. All procedures and protocols were followed appropriately. [Client A] was found in (sic) the sidewalk just outside of the home. Even with 1:1 staff for [client A] it would not be possible to prevent elopement attempts without a locked facility."</p> <p>The facility provided a report describing additional incidents as follows:</p> <p>9/1/12 "On Saturday at 12:00 PM [client A] attended Special Olympics</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Bowling with other clients. He returned home with other clients about 4:00 PM. At 7:00 PM [name of home] staff person discovered that her personal cell phone was missing. She asked [client A] if he had her phone and he denied any knowledge of the phone. The staff person reported the phone missing to her cell carrier who informed her that her phone had been used to access the Internet during the missing period. The cell company canceled her cell service to the missing phone. At 7:45 PM [client A] was observed coming downstairs going into the medication administration room. He was asked again if he knew the whereabouts of the missing phone. He began to swear and yell at staff with physically threatening gestures. He went to his room slamming doors after setting off the fire alarm. Staff went to medication room to get fire alarm key to reset the fire system. The key was missing but the missing cell phone had been placed in the drawer where the fire system key had been. [Client A] had been the only one in the medication room. The [name of home] Home Manager later reported that [client A] had called him from the missing staff's phone. At 8:03 PM on Saturday, 9/1/12, [client A] was observed to shut off door alarm while staff attempted to silence the fire alarm he had off. Staff called to [client A]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>following him on foot. He ran quickly ahead of her. Another staff implemented AWOL (Absent Without Leave) procedures including notifications. She followed him then by car finding him at nearby convenience store. He was out of her sight for approximately 5 minutes. When staff approached him he ran again towards the [name of home]. Staff followed him in her car until he reached the [name of home] where he refused to come into the house. Staff continued to monitor him. At 9:18 PM, Special Olympics Coordinator, [coordinator's name] called the [name of home] to report that another consumer at Special Olympics had reported that their phone was stolen. He reported that [client A] and another [name of home] resident were sitting next to the consumer whose phone was stolen and that they were bragging that they had a new cell phone. He stated that he would send someone to the home to pick up the phone. Staff asked [client A] and the other resident if they had a phone taken from Special Olympics. They denied stealing the phone. Staff asked again indicating that the coordinator of Special Olympics had called and that they would be coming to pick up phone. [Client A] reportedly went upstairs and produced the phone from his pocket when he came back down. It was given to Special Olympics</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>representative who informed [client A] and other resident that they were banned from Special Olympics for six months to a year. At 10:28 PM, [client A] came downstairs into the kitchen. Staff inquired why he was still up. He told staff he wanted a drink of water. He got a drink and returned to his room. At 10:34 PM he came downstairs proceeding to unlock door, disarm alarm, and attempted to leave. Staff repeatedly tried to reason and redirect [client A]. He yelled '---- you, I do what I want.' He became physically aggressive with staff, shoving her out of the way and leaving the home. Staff observed him until he was out of sight running toward [name of] convenience store. Staff implemented AWOL procedures including notifications. It was approximately 10:40 PM when she lost sight of [client A]. Additional staff were called to initiate search. [Client A] was found at approximately 11:00 PM at the [name of] convenience store. She asked [client A] to get into her car but he walked toward the [name of home]. Staff followed in her car requesting again for [client A] to get into her car. [Client A] responded '---- you.' He arrived at the [name of home] at 11:15 PM went upstairs and changed clothes. He came back downstairs stating that he wanted to watch TV (television). Staff kept [client A] in line of sight and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>also exits. Within a few minutes he was not in sight. It was determined that he had crawled to the door around furniture as staff searched, exiting the home about 11:30 PM. Another staff implemented AWOL procedures including notifications. Staff immediately left in her car to search the neighborhood, returning to [name of] Convenience store to check for [client A]. He was not at store. As staff was leaving the Convenience store parking lot, she noticed a number of 'somewhat suspicious looking' individuals loitering and coming in and out of a dilapidated residence nearby. She stopped in front of the house and called to one of the individuals who came to her car. She reportedly warned them not to 'harbor' a resident of the [name of home]. The individual admitted knowing [client A] and called to him inside. [Client A] came out of the house and the individual forced [client A] to get into the car with staff. They arrived back at the [name of home] approximately 11:50 PM. [Client A] went to bed after speaking with behavior clinician with [client A] insisting 'I don't give a ----. I don't care!' The behavior clinician had informed [client A's] mother of the day's events. He went to bed. At his 2:30 bed check, a cell phone missing from the day program was found by his bed on the floor. [Client A] had been asked</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>repeatedly if he knew of its whereabouts. He had consistently denied any knowledge of its whereabouts."</p> <p>The facility's report also included the following:</p> <p>9/2/12 "The home manager of the [name of home] entered the house with a banking bag with house receipts and monies. [Client A] observed the manager sitting at dining room table attending to paperwork with the bag lying nearby. [Client A] handed the manager his bank bag at the table and left the room. Home manager immediately checked the bag and counted monies. He determined that one twenty dollar bill was missing from the bag. The home manager asked [client A] about the missing money. [Client A] denied taking the money. He angrily stomped to his room. In approximately 20 minutes the home manager was in the hallway upstairs near [client A's] room. [Client A] came out of his room and the home manager reminded [client A] that the missing money belonged to others and was needed by others. [Client A] became angry and aggressive, stomping, waving his arms, lunging at the manager in an intimidating fashion. As [client A] passed the manager in the hallway, the manager stepped back and [client A] severely shoved the home manager hitting</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the manager with open hands and then with fists clenched on the back and arms. The manager is a fit younger man and stood his ground but deflected and blocked the considerable punching utilizing nonviolent crisis intervention techniques. The home manager sustained multiple bruising from the attack. The home manager told [client A] he was making bad choices for his life. [Client A] then ran downstairs, going onto the back porch, punching the table and throwing chairs. He then walked around the house angrily with a sullen expression in a physically intimidating fashion. In about 30 minutes, another staff suggested that he return the money to the home manager. In another 30 minutes that staff again advised [client A] to make a 'good choice' and return the money to the home manager. She engaged him in an activity to facilitate calming. After about 15 minutes, [client A] reached into his pocket and returned the twenty dollar bill. Staff told [client A] he had made a good choice. [Client A] was compliant for the remainder of the day."</p> <p>9/9/12 "[Client A] was playing with clients in the home (turning lights on and off). The home staff redirected clients and reminded [client A] that it was almost time to go to bed. [Client A] darted in the opposite direction and went out the back</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>door of the home. Staff verified that he had not come back in the house through the other door and was hiding within the house. Staff began looking in areas of the neighborhood that he frequents when AWOL. [Client A] was located within 10 - 15 minutes of his leaving the [name of home]. He was at the carwash near the [name of] station using his phone. When [client A] saw staff he did return to the home with staff. When asked why he left the home without staff; [client A] stated that he just went for a walk."</p> <p>9/10/12 "It was reported to the residential provider, [name of provider], that [client A] stole a staff person's cell phone last week at the workshop provider, [name of workshop]. He returned the stolen phone the same day after being confronted about the theft. Additionally today [client A] asked his workshop supervisor to take out some trash. He was given permission. While taking the trash out, [client A] got into a staff person's parked vehicle and rummaged through the contents of the vehicle. After a few minutes had passed and [client A] did not return to the workshop floor, staff went outside to locate [client A]. When staff approached the car, [client A] got out of car and crouched near the ground hiding until staff could locate him. He was escorted back into the workshop. He was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/25/2013	
NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>suspended and sent home."</p> <p>9/14/12 "[Client A] was asked to bring his laundry from his upstairs bedroom. Staff observed him ascend and then descend the stairway upon his return. When [client A] came back down the stairs, he was without his laundry and walked around the corner and out the back door. One staff person followed all notification protocols regarding elopement while the other staff person attempted to follow [client A]. The staff person lost sight of [client A] but was able to locate him a few blocks away near the [name of gas] Station coming from an alley or apartment building. [Client A] returned to the [name of home] without further incident. The incident lasted less than 30 minutes."</p> <p>Client A's 6/23/12 ISP (Individual Support Plan) was revised on 8/1/12 and indicated client A was admitted to the group home on 6/28/12. The Psychiatric Follow-up Evaluation dated 9/26/12 indicated a psychotropic medicine change of Prozac to be dropped, and Depakote and Seroquel added for impulse control.</p> <p>Client A's BSPs (Behavior Support Plans) with effective dates of June 2012 to June 2013 indicated the following behaviors:</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>- "Non-Compliance defined as refusing to complete a chore, bathe, go to day program or medical appointments or other necessary tasks. He may also become verbally aggressive when given direction.</p> <p>- Stealing defined as stealing items from stores, from staff or other clients. He most typically steals phones, I Pods, or cigarettes. When confronted he may deny stealing the item. He may hide the item he has stolen.</p> <p>- Elopement/AWOL defined as wandering away or going AWOL when he is agitated, bored, or wanting to go into the community alone.</p> <p>- Aggression defined as screaming, yelling, and/or cussing. He may be verbally abusive or accuse others of his own behavior. He may refuse tasks/chores. Behaviors may escalate to physical aggression."</p> <p>The Behavioral Review reports provided for review indicated the following:</p> <p>In June/July, 2012, client A had 3 episodes of non-compliance, 0 episodes of stealing, 1 episode of aggression. Note: "[client A] was admitted 6/20/12. Baseline data is being collected for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>June/July. He seems to be transitioning well to the new home."</p> <p>In August, 2012, client A had 6 episodes of non-compliance, 0 episodes of stealing, 1 episode of aggression. Note: "[Client A] seems to be adjusting well to the home. No visits home with family as of yet. [Client A] has been somewhat intimidated by another client that has exited the home at the end of this month. [Client A] and another young male client in home seem to have a good friendship. Some challenging of staff with non-compliant behaviors is noted."</p> <p>In September, 2012, client A had 19 episodes of non-compliance, 8 episodes of stealing, 11 episodes of aggression and 5 episodes of elopement/AWOL. Note: "New BSP for elopement/AWOL was added this month. Many behaviors this month and many behavior interventions implemented. Double staffing at peek (sic) times for AWOL and line of sight during all waking hours. Physical aggression and assault of 2 staff people. Many problems during visit home with family."</p> <p>In October, 2012, client A had 17 episodes of non-compliance, 6 episodes of stealing, 5 episodes of aggression, and 1 episode of elopement/AWOL. Note:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/25/2013
NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>"One incident of [client A] attempting AWOL at [name of workshop]. Stealing food from others at workshop and at home. Found going through other clients' items in their room. Very agitated when confronted about stolen items. Double staffing at peek (sic) times for AWOL and line of sight during all waking hours."</p> <p>In November, 2012, client A had 9 episodes of non-compliance, 3 episodes of stealing, 5 episodes of aggression, and 1 episode of elopement/AWOL. Note: "[Client A] attempted AWOL one time this month. Staff were able to maintain visual contact at all times. [Client A] called police in regards to a phone call he had made. The person he dialed became angry with him and verbally threatened [Client A]."</p> <p>In December, 2012, client A had 17 episodes of non-compliance, 6 episodes of stealing, 7 episodes of aggression and 1 episode of elopement/AWOL. Note: "One AWOL attempt. Staff were able to stay in pursuit of [client A] on the property as he ran in and out of the house. [Client A] stole 2 cell phones, tobacco, lighter, money, DVDs, CDs, clothing belonging to housemates, along with various other items. [Client A] was aggressive with other clients when confronted with stealing items. He threw</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the items at the other clients."</p> <p>In January, 2013, client A had 36 episodes of non-compliance, 8 episodes of stealing, 4 episodes of aggression, and 3 episodes of elopement/AWOL. Note: "3 incidents of [client A] attempting AWOL but staff were able to maintain visual contact with [client A]. Stealing continues to be a problem. Few reinforcers have been successful. [Client A] has been stealing cigarettes and hiding them behind his bed."</p> <p>In February, 2013, client A had 51 episodes of non-compliance, 15 episodes of stealing, 23 episodes of aggression, and 5 episodes of elopement/AWOL. Note: "[Client A] attempted AWOL 5 times this month. Staff were able to maintain visual contact at all times for each of these events. Punched and kicked the van door and window. Grabbed staff's wrist and thumb. Has had to be redirected from horseplay and rough house type behaviors with other clients."</p> <p>In March, 2013, client A had 28 episodes of non-compliance, 6 episodes of stealing, 11 episodes of aggression and 1 episode of elopement/AWOL. Note: "[Client A] went home for Easter with mother. She reported that he eloped from her house (see reportable incident.)"</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/25/2013	
NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Stealing continues to be a problem. Few reinforcers have been successful."</p> <p>The Abuse and Neglect Policy dated January 2012 was reviewed on 4/15/13 at 1:30 PM. The policy indicated reasonable suspicion of a crime against a client includes but is not limited to the following: " Emotional/verbal abuse of a client; . Alleged, suspected or actual neglect of a client...."</p> <p>The "Unauthorized Client Absences (AWOL)" policy, undated, was reviewed 4/16/13 at 2:00 PM. The procedures in the policy indicated, "When a client is show (sic) to frequently exhibit unauthorized absences, the (IDT) Interdisciplinary Team shall meet to discuss the client's absences and develop appropriate goals/objectives for dealing with such behavior." The facility failed to provide any IDT meeting notes of meetings discussing client A's AWOL behavior.</p> <p>Interview with Staff #1, Administrator, on 4/17/13 at 11:30 AM indicated client A had some of the other clients in the home trying to copy his actions. Staff #1, Administrator, stated client A "intimidated" his peers to get them to do</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>what he wanted. Staff #1, Administrator, stated it was difficult for the staff to keep up with him when client A went AWOL because he was "very" fast and would hide behind buildings. Staff #1, Administrator, stated client A's mother indicated she "always" checked his pockets when he came home to see what he had taken while he was out. Staff #1, Administrator, indicated client A needed to be in a more restrictive environment because of his stealing and AWOL behavior.</p> <p>Interview with staff #2, HM (Home Manager), on 4/16/13 at 9:00 AM indicated the home had an extra staff in the home during all waking hours. Staff #2, HM, indicated a second staff stayed in the home until midnight because of client A attempting to go AWOL. Staff #2, HM, stated client A was "very good in taking advantage of staff looking away or getting distracted by another client." Staff #2, HM, stated client A "always" became upset when being questioned about items that were missing.</p> <p>This federal tag relates to complaint #IN00127087.</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/25/2013	
NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 1 allegation of abuse for 1 of 4 sampled clients (client A), the facility failed to conduct a thorough investigation of the allegation of abuse.</p> <p>Findings include:</p> <p>The facility incident reports were reviewed on 4/15/13 at 1:05 PM. An incident report dated 4/5/13 indicated the following: "Day program staff were discussing with [client A] his recent behaviors and why he had eloped from the group home twice and had taken property from another client at the day program. [Client A] told the day program staff that he eloped 'Because [Home Manager] cussed at me.' Day Program staff notified [provider] administrative staff immediately."</p> <p>"[Provider] suspended group home manager, [Home Manager] pending an investigation. Staff present at the time of the alleged incident were interviewed. [Home Manager] admitted using a profane word while talking with [client A] and said that he apologized at the time that he said the word. There were 2 other</p>	W000154	The administrator conducted an interview with client A. A revised investigation form has been produced that provides space available to include detailed notes from interviews. This form will be utilized for all investigations. The director of operations will monitor for compliance.	05/25/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>staff present at the time of the incident."</p> <p>Interview with Staff #2, Administrator, on 4/17/13 at 3:00 PM indicated they had not documented the interviews with the other staff present and had not discussed the incident with client A.</p> <p>This federal tag relates to complaint #IN00127087.</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/25/2013	
NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000323	<p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview for 4 of 4 sampled clients (clients A, B, C, and D), the facility failed to ensure annual hearing evaluations had been conducted.</p> <p>Findings include:</p> <p>The record review for client A was conducted on 4/16/13 at 12:43 PM. The record indicated client A had received his annual physical examination on 6/8/12. The record did not indicate client A had ever received a hearing evaluation.</p> <p>The record review for client B was conducted on 4/16/13 at 1:35 PM. The record indicated client B had received his annual physical examination on 3/4/13. The record did not indicate client B had ever received a hearing evaluation.</p> <p>The record review for client C was conducted on 4/16/13 at 2:35 PM. The record indicated client C had received his annual physical examination on 1/30/13. The record did not indicate client C had ever received a hearing evaluation.</p> <p>The record review for client D was</p>	W000323	<p>An appointment with the physician will be scheduled for this client. The hearing portion of the documentation will be returned to the physician for completion. All other clients' charts will be reviewed by the nurse. Any incomplete documents will be scheduled with physician for completion. The nurse will insure that all annual physician visit documentation will be completed with required screening and assessments.</p>	05/25/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>conducted on 4/16/13 at 2:15 PM. The record indicated client D had received his annual physical examination on 9/14/12. The record did not indicate client D had ever received a hearing evaluation.</p> <p>Interview with staff #3, RN (Registered Nurse) on 4/17/13 at 2:00 PM indicated there was no record of hearing evaluations being conducted for clients A, B, C, and D.</p> <p>9-3-6(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/25/2013	
NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000407	<p>483.470(a)(1) CLIENT LIVING ENVIRONMENT The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (client A), the facility failed to ensure the client was properly placed in regard to his social, behavioral and psychiatric needs.</p> <p>Findings include:</p> <p>The facility's incident reports were reviewed on 4/15/13 at 1:05 PM. The reportable incident reports indicated the following:</p> <p>-4/4/13 "[Client A] ignored staff's prompts to join other clients in the game room for an activity choosing instead to dart out the backdoor and run down the street. Staff were able to keep visual contact at all times. Staff were able to convince him to return home after a few minutes."</p> <p>-4/3/13 "[Client A] was in the living room talking with the home manager about a cell phone that was in his possession that did not belong to him. He became angry and ran out the door of the</p>	W000407	<p>Client A was admitted to the group home on 6/28/12. Behaviors were not fully disclosed by family members either in frequency, intensity or even target behaviors. Client A's behaviors, though problematic, were within normal limits until September of 2012. Many adaptations were made to client A's program, staffing, and physical environment in attempts to better serve the needs of client A. Adaptations and protective measures were instituted to protect other clients within the home as well.</p> <p>Support team members agreed that a more restrictive placement would better serve client A and the other clients in the home. Client A was referred for a more restrictive placement (ESN) the week of 9/24/12. In the more than seven months since this client was referred no placements options have been available for client A.</p>	05/25/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/25/2013
NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>home and darted down the street. AWOL procedures were implemented by staff and his BSP (Behavior Support Plan) was followed. The police were notified. Staff located [client A] a few blocks from the home in a game store. Staff were able to convince [client A] to willingly return home. [Client A] was AWOL for approximately 2 hours and 15 minutes."</p> <p>-3/30/13 "[Client A's] mother reported today (4/3/13 @ (at) 3 PM) that on Saturday (3/30/13) [client A] was in the yard with her husband. Her husband looked down at an item in the yard. When he glanced toward where [client A] was standing near him, [client A] was running away down the street. He ran to a neighbor's property in a rural area before [client A's] parents were able to catch up to him and convince him to come home."</p> <p>3/27/13 "[Client A] got into an argument with another client. [Client A] punched the client in the chest leaving a red mark. The client complained of pain and the nurse assessed the injury."</p> <p>12/2/12 "Upon returning to the group home from an outing to a [name of school/city] basketball game. [Client A] walked around the staff person who was attending to him. When the staff person turned to redirect him, he was out of sight</p>		<p>Quality Community Services is terminating placement for client A. Until the time of discharge, Quality Community Services will continue the current program, staffing, and physical environmental supports for client A.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and had darted away. The 2 staff people on duty initiated AWOL procedures/notifications searching the house immediately and calling the home manager. [Client A] was not in direct line of sight for approximately 5 minutes." Follow-up report dated 12/7/12 indicated the following: "[Client A] darted past the staff person that was zoning him at that time. The staff person tried to follow and maintain visual contact but was unable to match [client A's] speed. The group home is a very large older home with 2 stories and many rooms. This makes it difficult to determine if [client A] has eloped or just darting quickly away from staff and going to another area of the house. The staff followed procedures and searched the house first before beginning the exterior search and AWOL notification protocols. All procedures and protocols were followed appropriately. [Client A] was found in (sic) the sidewalk just outside of the home. Even with 1:1 staff for [client A] it would not be possible to prevent elopement attempts without a locked facility."</p> <p>The facility provided a report describing additional incidents as follows:</p> <p>9/1/12 "On Saturday at 12:00 PM [client A] attended Special Olympics Bowling with other clients. He returned</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>home with other clients about 4:00 PM. At 7:00 PM [name of home] staff person discovered that her personal cell phone was missing. She asked [client A] if he had her phone and he denied any knowledge of the phone. The staff person reported the phone missing to her cell carrier who informed her that her phone had been used to access the Internet during the missing period. The cell company canceled her cell service to the missing phone. At 7:45 PM [client A] was observed coming downstairs going into the medication administration room. He was asked again if he knew the whereabouts of the missing phone. He began to swear and yell at staff with physically threatening gestures. He went to his room slamming doors after setting off the fire alarm. Staff went to medication room to get fire alarm key to reset the fire system. The key was missing but the missing cell phone had been placed in the drawer where the fire system key had been. [Client A] had been the only one in the medication room. The [name of home] Home Manager later reported that [client A] had called him from the missing staff's phone. At 8:03 PM on Saturday, 9/1/12, [client A] was observed to shut off door alarm while staff attempted to silence the fire alarm he had off. Staff called to [client A] following him on foot. He ran quickly</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>ahead of her. Another staff implemented AWOL (Absent Without Leave) procedures including notifications. She followed him then by car finding him at nearby Convenience store. He was out of her sight for approximately 5 minutes. When staff approached him he ran again towards the [name of home]. Staff followed him in her car until he reached the [name of home] where he refused to come into the house. Staff continued to monitor him. At 9:18 PM, Special Olympics Coordinator, [coordinator's name] called the [name of home] to report that another consumer at Special Olympics had reported that their phone was stolen. He reported that [client A] and another [name of home] resident were sitting next to the consumer whose phone was stolen and that they were bragging that they had a new cell phone. He stated that he would send someone to the home to pick up the phone. Staff asked [client A] and the other resident if they had a phone taken from Special Olympics. They denied stealing the phone. Staff asked again indicating that the coordinator of Special Olympics had called and that they would be coming to pick up phone. [Client A] reportedly went upstairs and produced the phone from his pocket when he came back down. It was given to Special Olympics representative who informed [client A]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and other resident that they were banned from Special Olympics for six months to a year. At 10:28 PM, [client A] came downstairs into the kitchen. Staff inquired why he was still up. He told staff he wanted a drink of water. He got a drink and returned to his room. At 10:34 PM he came downstairs proceeding to unlock door, disarm alarm, and attempted to leave. Staff repeatedly tried to reason and redirect [client A]. He yelled '---- you, I do what I want.' He became physically aggressive with staff, shoving her out of the way and leaving the home. Staff observed him until he was out of sight running toward [name of] Convenience store. Staff implemented AWOL procedures including notifications. It was approximately 10:40 PM when she lost sight of [client A]. Additional staff were called to initiate search. [Client A] was found at approximately 11:00 PM at the [name of] Convenience store. She asked [client A] to get into her car but he walked toward the [name of home]. Staff followed in her car requesting again for [client A] to get into her car. [Client A] responded '---- you.' He arrived at the [name of home] at 11:15 PM went upstairs and changed clothes. He came back downstairs stating that he wanted to watch TV (television). Staff kept [client A] in line of sight and also exits. Within a few minutes he was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	not in sight. It was determined that he had crawled to the door around furniture as staff searched, exiting the home about 11:30 PM. Another staff implemented AWOL procedures including notifications. Staff immediately left in her car to search the neighborhood, returning to [name of] Convenience store to check for [client A]. He was not at store. As staff was leaving the Convenience store parking lot, she noticed a number of 'somewhat suspicious looking' individuals loitering and coming in and out of a dilapidated residence nearby. She stopped in front of the house and called to one of the individuals who came to her car. She reportedly warned them not to 'harbor' a resident of the [name of home]. The individual admitted knowing [client A] and called to him inside. [Client A] came out of the house and the individual forced [client A] to get into the car with staff. They arrived back at the [name of home] approximately 11:50 PM. [Client A] went to bed after speaking with behavior clinician with [client A] insisting 'I don't give a ----. I don't care!' The behavior clinician had informed [client A's] mother of the day's events. He went to bed. At his 2:30 bed check, a cell phone missing from the day program was found by his bed on the floor. [Client A] had been asked repeatedly if he knew of its whereabouts.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>He had consistently denied any knowledge of its whereabouts."</p> <p>The facility's report also included the following:</p> <p>9/2/12 "The home manager of the [name of home] entered the house with a banking bag with house receipts and monies. [Client A] observed the manager sitting at dining room table attending to paperwork with the bag lying nearby. [Client A] handed the manager his bank bag at the table and left the room. Home manager immediately checked the bag and counted monies. He determined that one twenty dollar bill was missing from the bag. The home manager asked [client A] about the missing money. [Client A] denied taking the money. He angrily stomped to his room. In approximately 20 minutes the home manager was in the hallway upstairs near [client A's] room. [Client A] came out of his room and the home manager reminded [client A] that the missing money belonged to others and was needed by others. [Client A] became angry and aggressive, stomping, waving his arms, lunging at the manager in an intimidating fashion. As [client A] passed the manager in the hallway, the manager stepped back and [client A] severely shoved the home manager hitting the manager with open hands and then</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>with fists clenched on the back and arms. The manager is a fit younger man and stood his ground but deflected and blocked the considerable punching utilizing nonviolent crisis intervention techniques. The home manager sustained multiple bruising from the attack. The home manager told [client A] he was making bad choices for his life. [Client A] then ran downstairs, going onto the back porch, punching the table and throwing chairs. He then walked around the house angrily with a sullen expression in a physically intimidating fashion. In about 30 minutes, another staff suggested that he return the money to the home manager. In another 30 minutes that staff again advised [client A] to make a 'good choice' and return the money to the home manager. She engaged him in an activity to facilitate calming. After about 15 minutes, [client A] reached into his pocket and returned the twenty dollar bill. Staff told [client A] he had made a good choice. [Client A] was compliant for the remainder of the day."</p> <p>9/9/12 "[Client A] was playing with clients in the home (turning lights on and off). The home staff redirected clients and reminded [client A] that it was almost time to go to bed. [Client A] darted in the opposite direction and went out the back door of the home. Staff verified that he</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>had not come back in the house through the other door and was hiding within the house. Staff began looking in areas of the neighborhood that he frequents when AWOL. [Client A] was located within 10 - 15 minutes of his leaving the [name of home]. He was at the carwash near the [name of gas] station using his phone. When [client A] saw staff he did return to the home with staff. When asked why he left the home without staff, [client A] stated that he just went for a walk."</p> <p>9/10/12 "It was reported] to the residential provider, [name of provider], that [client A] stole a staff person's cell phone last week at the workshop provider, [name of workshop]. He returned the stolen phone the same day after being confronted about the theft. Additionally today [client A] asked his workshop supervisor to take out some trash. He was given permission. While taking the trash out, [client A] got into a staff person's parked vehicle and rummaged through the contents of the vehicle. After a few minutes had passed and [client A] did not return to the workshop floor, staff went outside to locate [client A]. When staff approached the car, [client A] got out of car and crouched near the ground hiding until staff could locate him. He was escorted back into the workshop. He was suspended and sent home."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>9/14/12 "[Client A] was asked to bring his laundry from his upstairs bedroom. Staff observed him ascend and then descend the stairway upon his return. When [client A] came back down the stairs, he was without his laundry and walked around the corner and out the back door. One staff person followed all notification protocols regarding elopement while the other staff person attempted to follow [client A]. The staff person lost sight of [client A] but was able to locate him a few blocks away near the [name of] Station coming from an alley or apartment building. [Client A] returned to the [name of home] without further incident. The incident lasted less than 30 minutes."</p> <p>Client A's 6/23/12 ISP (Individual Support Plan) revised on 8/1/12 indicated client A was admitted to the group home on 6/28/12. The Psychiatric Follow-up Evaluation dated 9/26/12 indicated a psychotropic medicine change of Prozac to be dropped, and Depakote and Seroquel added for impulse control.</p> <p>Client A's BSPs (Behavior Support Plans) with effective dates of June 2012 to June 2013 indicated the following behaviors:</p> <p>- "Non-Compliance defined as refusing</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>to complete a chore, bathe, go to day program or medical appointments or other necessary tasks. He may also become verbally aggressive when given direction.</p> <p>- Stealing defined as stealing items from stores, from staff or other clients. He most typically steals phones, I Pods, or cigarettes. When confronted he may deny stealing the item. He may hide the item he has stolen.</p> <p>- Elopement/AWOL defined as wandering away or going AWOL when he is agitated, bored, or wanting to go into the community alone.</p> <p>- Aggression defined as screaming, yelling, and/or cussing. He may be verbally abusive or accuse others of his own behavior. He may refuse tasks/chores. Behaviors may escalate to physical aggression."</p> <p>The Behavioral Review reports provided for review indicated the following:</p> <p>In June/July, 2012, client A had 3 episodes of non-compliance, 0 episodes of stealing, 1 episode of aggression. Note: "[client A] was admitted 6/20/12. Baseline data is being collected for June/July. He seems to be transitioning well to the new home."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/25/2013	
NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>In August, 2012, client A had 6 episodes of non-compliance, 0 episodes of stealing, 1 episode of aggression. Note: "[Client A] seems to be adjusting well to the home. No visits home with family as of yet. [Client A] has been somewhat intimidated by another client that has exited the home at the end of this month. [Client A] and another young male client in home seem to have a good friendship. Some challenging of staff with non-compliant behaviors is noted."</p> <p>In September, 2012, client A had 19 episodes of non-compliance, 8 episodes of stealing, 11 episodes of aggression and 5 episodes of elopement/AWOL. Note: "New BSP for elopement/AWOL was added this month. Many behaviors this month and many behavior interventions implemented. Double staffing at peek (sic) times for AWOL and line of sight during all waking hours. Physical aggression and assault of 2 staff people. Many problems during visit home with family."</p> <p>In October, 2012, client A had 17 episodes of non-compliance, 6 episodes of stealing, 5 episodes of aggression, and 1 episode of elopement/AWOL. Note: "One incident of [client A] attempting AWOL at [name of workshop]. Stealing</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/25/2013	
NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>food from others at workshop and at home. Found going through other clients' items in their room. Very agitated when confronted about stolen items. Double staffing at peek (sic) times for AWOL and line of sight during all waking hours."</p> <p>In November, 2012, client A had 9 episodes of non-compliance, 3 episodes of stealing, 5 episodes of aggression, and 1 episode of elopement/AWOL. Note: "[Client A] attempted AWOL one time this month. Staff were able to maintain visual contact at all times. [Client A] called police in regards to a phone call he had made. The person he dialed became angry with him and verbally threatened [Client A]."</p> <p>In December, 2012, client A had 17 episodes of non-compliance, 6 episodes of stealing, 7 episodes of aggression and 1 episode of elopement/AWOL. Note: "One AWOL attempt. Staff were able to stay in pursuit of [client A] on the property as he ran in and out of the house. [Client A] stole 2 cell phones, tobacco, lighter, money, DVDs, CDs, clothing belonging to housemates,, along with various other items. [Client A] was aggressive with other clients when confronted with stealing items. He threw the items at the other clients."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/25/2013	
NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>In January, 2013, client A had 36 episodes of non-compliance, 8 episodes of stealing, 4 episodes of aggression, and 3 episodes of elopement/AWOL. Note: "3 incidents of [client A] attempting AWOL but staff were able to maintain visual contact with [client A]. Stealing continues to be a problem. Few reinforcers have been successful. [Client A] has been stealing cigarettes and hiding them behind his bed."</p> <p>In February, 2013, client A had 51 episodes of non-compliance, 15 episodes of stealing, 23 episodes of aggression, and 5 episodes of elopement/AWOL. Note: "[Client A] attempted AWOL 5 times this month. Staff were able to maintain visual contact at all times for each of these events. Punched and kicked the van door and window. Grabbed staff's wrist and thumb. Has had to be redirected from horseplay and rough house type behaviors with other clients."</p> <p>In March, 2013, client A had 28 episodes of non-compliance, 6 episodes of stealing, 11 episodes of aggression and 1 episode of elopement/AWOL. Note: "[Client A] went home for Easter with mother. She reported that he eloped from her house (see reportable incident.) Stealing continues to be a problem. Few reinforcers have been successful."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>During the observation period on 4/16/13 from 4:00 PM to 7:10 PM, client A came into the living room of the home at 5:25 PM and used his cell phone to call a friend. Client G and client H were watching television. Client G asked client A if he could say "hi" to the person on the phone. Client A told him no and continued talking on the phone. When client A finished his call he took the remote from client H and changed the station. Client H indicated he wanted to watch the other station, but client A indicated he wanted to watch the show he had turned on. Client H apologized to client A.</p> <p>Interview with Staff #1, Administrator, on 4/17/13 at 11:30 AM indicated client A had some of the other clients in the home trying to copy his actions. Staff #1, Administrator, stated client A "intimidated" his peers to get them to do what he wanted. Staff #1, Administrator, stated it was difficult for the staff to keep up with him when he went AWOL because he "was very fast" and would hide behind buildings. Staff #1, Administrator, indicated client A needed to be in a more restrictive environment because of his stealing and AWOL behavior. Staff #1, Administrator, indicated client A's home was near stores</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and a bar making it difficult for them to ensure his safety.</p> <p>Interview with staff #2, HM (Home Manager), on 4/16/13 at 9:00 AM indicated the home had an extra staff in the home during all waking hours. Staff #2, HM, indicated a second staff stayed in the home until midnight because of client A attempting to go AWOL. Staff #2, HM, stated client A was "very good in taking advantage" of staff looking away or getting distracted by another client.</p> <p>This federal tag relates to complaint #IN00127087.</p> <p>9-3-7(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/25/2013	
NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review, and interview for 2 of 4 sampled clients (client A and B), the facility failed to ensure their recommended diets were followed.</p> <p>Findings include:</p> <p>The evening observations was conducted on 4/16/13 from 4:00 PM to 7:10 PM. The evening meal was served at 6:30 PM. The meal consisted of Chicken Alfredo with spaghetti, steamed broccoli, and salad with dressing. Client A took a large second helping of the Chicken Alfredo and client B took 2 additional servings of the Chicken Alfredo. Staff did not encourage the clients to eat more salad or broccoli instead of the Chicken Alfredo.</p> <p>The record review for client A was conducted on 4/16/13 at 12:43 PM. The record indicated client A was on a regular diet with no caffeine, NCS (no concentrated sweets) with portion control. The client could have seconds on non-starchy vegetables and sugar free beverages.</p> <p>The record review for client B was</p>	W000460	Staff will be retrained on procedures and following prescribed diets. Staff will be retrained to offer healthy choices with documentation of refusals to follow prescribed diets. The Director of Operation and the QMRP will retrain the home managers and staff. The home manager will monitor for compliance.	05/25/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>conducted on 4/16/13 at 1:35 PM. The record indicated client B was on a regular diet with NCS and portion control. The client could have seconds only on non-starchy vegetables and SF (sugar free) beverages.</p> <p>Interview with staff #2, Home Manager, on 4/16/13 at 7:00 PM indicated the clients liked the Chicken Alfredo but the staff should have suggested they eat more salad and broccoli instead of the Alfredo.</p> <p>9-3-8(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/25/2013	
NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000473	<p>483.480(b)(2)(ii) MEAL SERVICES Food must be served at appropriate temperature. Based on observation and interview for 1 of 4 sampled clients (client A) and 3 additional clients (clients F, G, and H), the facility failed to ensure staff served food within 15 minutes of removal from stove.</p> <p>Findings include:</p> <p>The morning observation was conducted on 4/16/13 at 6:45 AM to 9:00 AM. Clients B and H were sitting at the dining table at 6:45 AM and client B was eating his breakfast. Client H was looking at the newspaper with his plate of food in front of him. Client H started eating his food at 7:03 AM. The breakfast consisted of fried eggs, bacon, fruit cocktail and orange juice. The dining table also had three other plates of food prepared and waiting for clients to come and eat. Client A and client G came to the table at 7:15 AM and ate their plates of food. Client F came to the dining room at 7:30 AM. Client F signed to staff she wanted to warm her food and went into the kitchen, put the fruit salad into a bowl and put the eggs and bacon into the microwave to heat.</p> <p>Interview with staff #4 at 7:00 AM on</p>	W000473	<p>The staff and home manager will be retrained in food sanitation procedures. The Director of Operations and QMRP will retrain the staff and home manager. The home manager will monitor for compliance.</p>	05/25/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>4/16/13 indicated the clients usually helped her prepare the breakfast, but she did it today to make sure everything got done in time for them to leave for work by 8:00 AM.</p> <p>Interview with staff #1, Administrator, on 4/22/13 at 11:30 AM stated they had "numerous" meetings on the amount of time the food was to be left on the table. Staff #1, Administrator, indicated the staff should not have prepared the food and it should not have been on the table more than 15 minutes.</p> <p>9-3-8(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/25/2013
NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W000479	<p>483.480(c)(1)(iii) MENUS Menus must be different for the same days of each week and adjusted for seasonal changes. Based on record review, observation and interview for 4 of 4 sampled clients (clients A, B, C, and D) and 4 additional clients (clients E, F, G, and H), the facility failed to provide a different menu each week.</p> <p>Findings include:</p> <p>The evening observation was conducted on 4/16/13 from 4:00 PM to 7:10 PM. The evening meal was served at 6:30 PM to clients A, B, C, D, E, F, G and H. The meal consisted of chicken Alfredo with spaghetti, steamed broccoli and salad with dressing. Review of the undated menu hanging on the refrigerator for 4/15/13 at 5:00 PM was for one week. Staff #3 stated at 5:15 PM they only had the one week menu and used it "over and over." Staff #3 indicated they always had turkey burgers on Monday and chicken Alfredo on Tuesday. Staff #3 indicated it had been some time since the menu had changed.</p> <p>Interview with Staff #1, Administrator, on 4/22/13 at 11:30 AM indicated they were using the same menu in all of their homes and only had the one currently. Staff #1,</p>	W000479	A set of four menus with seasonal options will be developed with clients input and dietitian recommendations. The menus will be rotated weekly. The home manager will implement and monitor this correction.	05/25/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Administrator, indicated they were in the process of getting a new menu.</p> <p>9-3-8(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W009999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met.</p> <p>460 IAC 9-3-2 Resident Protections</p> <p>(c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is: (3) conviction of a crime substantially related to a dependent population or any violent crime. The provider shall obtain, as a minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5, and three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section.</p> <p>This State Rule is not met as evidenced by:</p> <p>Based on record review and interview for 1 of 3 staff (Staff #5) personnel files, the facility failed to ensure three references were obtained prior to employment.</p> <p>Findings include:</p>	W009999	<p>The HR coordinator will insure that three or more reference checks will be completed for each potential employee. When three references of work type experience are not available, personal references will be accepted. This will be monitored by the HR coordinator and HR manager.</p>	05/25/2013
---------	--	---------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The personnel files were reviewed on 4/15/13 at 3:32 PM. Review of 3 staff records indicated staff #5 had not provided three references prior to coming to work. The record indicated staff #5 had one reference and 2 verifications of employment only.</p> <p>Interview with Staff #6, administrator, on 4/16/13 at 2:00 PM indicated she was not aware the verification of employment wasn't sufficient for a reference.</p> <p>9-3-2(c)</p>			